State of Indiana Member Copayment Schedule

Annual maximum on all dental services is $1,000.00

Office visits are subject to a $5.00 copayment

CDT 4 CODE	PROCEDURE NAME	YOU PAY
DIAGNOSTIC		
D00120	Periodic Oral Evaluation	0
D00140	Limited Oral Evaluation	0
D00150	Comprehensive Oral Evaluation	0
D00210	Intraoral – Complete Series (Including Bitewings)	0
D00220	Intraoral – Periapical – First Film	0
D00230	Intraoral – Periapical – Each Additional Film	0
D00240	Intraoral – Occlusal Film	0
D00270	Bitewings – Single Film	0
D00272	Bitewings – Two Films	0
D00274	Bitewings – Four Films	0
D00330	Panoramic Film	0
D00460	Pulp Vitality Tests	0
D00470	Diagnostic Casts	0
PREVENTIVE		
D01110	Prophylaxis – Adult	0
D01120	Prophylaxis – Child	0
D01201	Topical Application Of Fluoride (Including Prophylaxis) – Child	0
D01203	Topical Application Of Fluoride (Excluding Prophylaxis) – Child	0
D01310	Dietary Planning, Oral Hygiene Instruction	0
D01330	Dietary Planning, Oral Hygiene Instruction	0
D01351	Sealant Application – Per Tooth	6
D01510	Space Maintainers	Lab Fee Only
D01525	Space Maintainers	Lab Fee Only
D09110	Palliative (Emergency) Treatment Of Dental Pain Minor Procedures	0
RESTORATIVE		
Precious (high noble metal) and semi precious metals (noble metal), if used, will be charged to the patient at the additional cost of the metal. This applies to inlays, crowns, bridges, and cast post and cores.		
D01351	Sealant Application	6
D02140	Amalgam – One Surface, Primary Or Permanent	9
D02150	Amalgam – Two Surfaces, Primary Or Permanent	12
D02160	Amalgam – Three Surfaces, Primary Or Permanent	14
D02161	Amalgam – Four Or More Surfaces, Primary Or Permanent	17
D02330	Resin Based Composite – One Surface, Anterior	11
D02331	Resin Based Composite – Two Surfaces, Anterior	14
D02332	Resin Based Composite – Three Or More Surfaces, Anterior	19
D02335	Resin Based Composite – Four Or More Surfaces Or Involving Incisal Angle (Anterior)	22
D02510	Inlay – Metallic One Surface	85
D02520	Inlay – Metallic Two Surface	95
D02530	Inlay – Metallic Three Surface	100
D02542	Onlay – Metallic – Two Surfaces	100
D02543	Onlay – Metallic – Three Surfaces	100
D02544	Onlay – Metallic – Four Or More Surfaces	100
D02740	Crown – Porcelain / Ceramic Substrate	95
D02750	Crown – Porcelain Fused To High Noble Metal	95
D02751	Crown – Porcelain Fused To Predominantly Base Metal	95
D02752	Crown – Porcelain Fused To Noble Metal	95
D02780	Crown – 3/4 Cast High Noble Metal	100
D02781	Crown – 3/4 Cast Predominantly Base Metal	100
D02782	Crown – 3/4 Cast Noble Metal	100
D02790	Crown – Full Cast High Noble Metal	95
D02791	Crown – Full Cast Predominantly Base Metal	95
D02792	Crown – Full Cast Noble Metal	95
D02910	Recement Inlay	8
D02920	Recement Crown	8
D02930	Prefabricated Stainless Steel Crown – Primary Tooth	22
D02940	Sedative Filling	9
D02950	Core Buildup, Including Any Pins	22
RESTORATIVE *(continued)*		
D02951	Pin Retention – Per Tooth, In Addition To Restoration	12
D02952	Cast Post And Core In Addition To Crown	35
D02954	Prefabricated Post And Core In Addition To Crown	30
D02970	Temporary Crown (Fractured Tooth) (B/R)	20
ENDODONTICS		
D00150*	Specialist Consultation And Diagnostics*	0
D03110	Pulp Capping (Direct)	0
D03120	Pulp Capping (Indirect)	0
D03220	Therapeutic Pulpotomy (Excluding Final Restoration)	0
D03310	Root Canal Therapy – Anterior (Excluding Final Restoration	0
D03320	Root Canal Therapy – Bicuspid (Excluding Final Restoration)	0
D03330	Root Canal Therapy – Molar (Excluding Final Restoration)	0
D03410	Apicoectomy / Periradicular Surgery - Anterior	0
D03421	Apicoectomy / Periradicular Surgery – Bicuspid (First Root)	0
D03425	Apicoectomy / Periradicular Surgery – Molar (First Root)	0
D03430	Retrograde Filling – Per Root	0
*	Evaluations provided by an Endodontic Specialist have no copayment	
PERIODONTICS		
D00180*	Specialists Comprehensive Perio Exam And Evaluation	14
D04210	Gingivectomy Or Gingivoplasty – Four Or More Contiguous Teeth Or Bounded Teeth Spaces, Per Quadrant	75
D04240	Gingival Flap Procedure, Including Root Planing – Four Or More Contiguous Teeth Or Bounded Teeth Spaces, Per Quadrant	85
D04260	Osseous Surgery (Including Flap Entry And Closure) Four Or More Contiguous Teeth Or Bounded Teeth Spaces, Per Quadrant	100
D04270	Pedicle Soft Tissue Graft Procedure	65
D04271	Free Soft Tissue Graft Procedure (Including Donor Site Surgery)	65
D04341	Periodontal Root Planing–Four Or More Contiguous Teeth Or Bounded Teeth Spaces, Per Quadrant	20
D04355	Full Mouth Debridement To Enable Comprehensive Evaluation	20
D07960	Frenectomy (Covered Under Oral Surgery)	25
D09951	Occlusal Adjustment – Limited	6
D09952	Occlusal Adjustment – Complete Per Appointment	22
*	Evaluations provided by a Periodontal Specialist have a copayment of $14	
PROSTHETICS REMOVABLE		
D05110	Complete Denture, Maxillary	125
D05120	Complete Denture, Mandibular	125
D05130	Denture-Immediate Upper	See Limitations
D05140	Denture-Immediate Lower	See Limitations
D05213	Maxillary Partial Denture – Cast Metal Framework With Resin (Including Any Conventional Clasps, Rests And Teeth)	145
D05214	Mandibular Partial Denture – Cast Metal Framework With Resin	145
D05410	Adjust Complete Denture – Maxillary	4
D05411	Adjust Complete Denture – Mandibular	4
D05421	Adjust Partial Denture – Maxillary	4
D05422	Adjust Partial Denture – Mandibular	4

CDT 4 CODE	PROCEDURE NAME	YOU PAY
PROSTHETICS REMOVABLE *(continued)*		
D05510	Repair Broken Complete Denture Base	10
D05520	Replace Missing Or Broken Teeth – Complete Denture (each tooth)	10
D05610	Repair Resin Denture Base	15
D05620	Repair Cast Framework	15
D05630	Repair Or Replace Broken Clasp	15
D05640	Replace Broken Teeth – Per Tooth	15
D05730	Reline Complete Maxillary Denture (Chairside)	35
D05731	Reline Complete Mandibular Denture (Chairside)	35
D05740	Reline Maxillary Partial Denture (Chairside)	35
D05741	Reline Mandibular Partial Denture (Chairside)	35
D05750	Reline Complete Maxillary Denture (Laboratory)	Lab Fee Only
D05751	Reline Complete Mandibular Denture (Laboratory)	Lab Fee Only
D05760	Reline Maxillary Partial Denture (Laboratory)	Lab Fee Only
D05761	Reline Mandibular Partial Denture (Laboratory)	Lab Fee Only
D05860	Overdenture	See Limitations
D05861	Overdenture	See Limitations
PROSTHETICS FIXED		
Precious (high noble metal) and semi precious metals (noble metal), if used, will be charged to the patient at the additional cost of the metal. This applies to inlays, crowns, bridges, and cast post and cores.		
D06210	Pontic – Cast High Noble Metal	100
D06211	Pontic – Cast Predominantly Base Metal	100
D06212	Pontic – Cast Noble Metal	100
D06240	Pontic – Porcelain Fused To High Noble Metal	100
D06241	Pontic – Porcelain Fused To Predominantly Base Metal	100
D06242	Pontic – Porcelain Fused To Noble Metal	100
D06545	Retainer – Cast Metal For Resin Bounded Fixed Prosthesis	55
D06606	Inlay Cast Noble Metal, Two Surfaces	65
D06607	Inlay Cast Noble Metal, Three Or More Surfaces	75
D06614	Onlay Cast Noble Metal, Two Surfaces	95
D06615	Onlay Cast Noble Metal, Three Or More Surfaces	95
D06750	Crown – Porcelain Fused To High Noble Metal	90
D06751	Crown – Porcelain Fused To Predominantly Base Metal	90
D06752	Crown – Porcelain Fused To Noble Metal	90
D06790	Crown – Full Cast High Noble Metal	90
D06791	Crown – Full Cast Predominantly Base Metal	90
D06792	Crown – Full Cast Noble Metal	90
D06930	Recement Fixed Partial Denture	11
D06970	Cast Post And Core In Addition To Fixed Partial Denture Retainer	35
D06971	Cast Post As Part Of Fixed Partial Denture Retainer	35
D06972	Prefabricated Post And Core In Addition To Fixed Partial Denture Retainer	35
ORAL SURGERY		
D00150*	Specialist Consultation And Diagnostics*	14
D07140	Extraction, Erupted Tooth Or Exposed Root (Elevation And/Or Forceps Removal)	0
D07210	Surgical Removal Of Erupted Tooth	21
D07220	Removal Of Impacted Tooth – Soft Tissue	25
D07230	Removal Of Impacted Tooth – Partially Bony	35
D07240	Removal Of Impacted Tooth – Completely Bony	45
D07280	Surgical Access Of An Unerupted Tooth	45
D07281	Surgical Exposure Of Impacted Or Unerupted Tooth To Aid Eruption	40
D07310	Alveoloplasty In Conjunction With Extractions – Per Quadrant	0
D07320	Alveoloplasty Not In Conjunction With Extractions – Per Quadrant	35

CDT 4 CODE	PROCEDURE NAME	YOU PAY
ORAL SURGERY *(continued)*		
D07510	Incision And Drainage Of Abscess – Intraoral Soft Tissue	8
D07960	Frenulectomy (Frenectomy Or Frenotomy) – Separate Procedure	25
D07970	Excision Of Hyperplastic Tissue – Per Arch	17
*	Evaluation Provided By An Oral Surgeon Have A Copayment Of $14	
ANESTHESIA		
D09211	Regional Block Anesthesia	0
D09212	Trigeminal Division Block Anesthesia	0
D09215	Local Anesthesia	0

ORTHODONTICS

50% benefit to a lifetime maximum payment of $750.00, which is separate from the annual $1000.00 maximum for all other services.

50% Patient benefit is applicable towards consultations, records, fees, treatment and retention.

Orthodontic treatment to correct malocclusion is limited to one course of Phase II Permanent Dentition treatment and retention. This would include office records, comprehensive full banding and/or bonding of the permanent dentition, the initial retention appliances and office visits for retention. Total coverage period for treatment and retention will be a maximum of 24 months. There will be no benefits paid for treatment or retention beyond the 24-month period. Determination of such expense for treatment and retention will be the responsibility of the subscriber and the treating dentist.

The 24 month period shall be defined as that 24 month period commencing with the initial banding and/or bonding of the case, as reported by the treating dentist, and extending up and including that date 24 months later.

Covered services include but are not limited to cephalometric film, post treatment stabilization. Orthognathic surgery is excluded from this benefit.

Services covered within the 24-month period.

D00340	Cephalometric Film (Included In Office Records)
D08750	Post Treatment Stabilization

OUT OF AREA EMERGENCY TREATMENT

If outside the geographical area of the designated dental group office (more than a 50-mile radius), Eligible Enrollees will be directly reimbursed for emergency treatment to a maximum of $50.00. Emergency treatment refers only to those dental services to alleviate pain and suffering.

ACCIDENTAL INJURY

There is no coverage for accidental injury. Accidental injury is defined as damage to the hard and soft tissues of the oral cavity resulting from force external to the mouth. Damages to the hard and soft tissues of the oral cavity from normal masticatory (chewing) function will be covered at the normal schedule of benefits.

STATE OF INDIANA DELTACARE EXCLUSIONS AND LIMITATIONS

LIMITATIONS

Prosthodontics (bridges, partial and full dentures)

A prosthodontic appliance will be provided only once in every four year period when determined by the dentist not to be functional or serviceable. Said four-year period will be measured from the date on which the existing appliance was last supplied. The term "existing" as used in this paragraph, is intended to include an appliance that was placed at the inception of the aforesaid four year period but which, for whatever reason, is no longer in the possession of the patient.

Fixed versus Removalable Appliance: If there are multiple spaces in the same arch, the benefit calls for a removable appliance. If there are one or two missing teeth in the same arch which can be replaced using a maximum of 4 units (a combination of retainers, and pontics), the benefit calls for a fixed bridge. If more than 4 units are required, the benefit calls for a removable appliance.

If a copayment is not delineated in the Schedule of Benefits, recementation of inlays and/or crown and bridges initially placed by the participating dentist are at no charge to the patient and/or recementation of pre-existing inlays, crown and bridges not placed by the participating dentist, are at the participating doctor's fee for service.

Partial Dentures: If the benefit calls for a removable appliance and a satisfactory result can be achieved by a standard cast chrome and/or acrylic partial denture, but the patient and dentist select a more personalized appliance or one involving specialized techniques, the obligation of the plan will be only the benefits appropriate to those procedures necessary to eliminate oral disease and restore missing teeth. The balance of the cost will remain the responsibility of the patient.

Complete Dentures: If a satisfactory result can be achieved through the utilization of standard procedures and materials, however the patient and the dentist select a more personalized appliance or one involving specialized techniques, the obligation of the plan will be any of the benefits appropriate to those procedures necessary to eliminate oral disease and restore missing teeth.

The balance of the cost will remain the responsibility of the patient. If an immediate denture is the treatment of choice, the benefit applied will be that of the conventional denture. The difference in cost, including the first reline, will be the responsibility of the patient.

Overdenture: If an overdenture is the treatment of choice, it is covered up to the limits of a standard denture. All other related services or procedures are not covered and would be charged fee for service (such as root canal therapy, post and core, special attachments and/or impressions).

Temporary Full or Partial Dentures: If the patient elects the temporary appliance in lieu of the conventional prosthesis, the copayment applied is for that of the conventional prosthesis and the patient has exhausted the benefit for the four year period.

RESTORATIVE (silver or tooth colored fillings, inlays, porcelain, metal or porcelain to metal crowns)

Inlays, porcelain, metal or porcelain to metal crowns: If a tooth can be restored with amalgam or composite resins, these will be the materials used to restore the tooth. The judgment will be solely that of the dentist providing the service.

If tooth colored resins are used to restore posterior teeth, the benefit applied will be that of the silver amalgam restoration. The difference in cost will be the responsibility of the patient.

The general dentist provider covers a restoration for abrasion or erosion only when there is a clinical recommendation.

MOUTH REHABILITATION

If the patient and the dentist select a course of mouth rehabilitation, the obligation of the plan will be to apply coverage to those benefits appropriate to procedures necessary to eliminate oral disease and replace missing teeth. The balance of the treatment, including costs to increase vertical dimension or restore the occlusion, will remain the responsibility of the patient.

ORTHODONTICS (Limited to Phase II Permanent Dentition)

(Moving teeth to correct their position in existing bone and is applicable when orthodontic services are included on the Schedule of Benefits)

Orthodontics will only be provided when, in the opinion of the orthodontic consultant, a satisfactory result can be achieved.

Cross bite in permanent teeth will only be treated when, in the opinion of the orthodontic consultant, other conditions are present which would indicate that orthodontic treatment is necessary.

The Schedule of Benefits defines the maximum length of time the patient is covered for orthodontic care. Treatment which is extended due to the patient's failure to abide by the orthodontist's recommendations and/or keeping scheduled appointments shall be the patient's additional financial responsibility.

Space maintainers are covered when provided by the primary general dentist. When provided by an orthodontist, the patient is responsible for the full fee for service charge of the orthodontists.

When cosmetic procedures such as porcelain brackets and lingual appliances are the treatment of choice, the subscriber is responsible for the additional charges above the use of standard and/or brackets and facial appliances.

SPECIALTY REFERRALS

Specialty services will only be covered when there is an authorized (signed) referral made by the primary General Dentist.

DHMO EXCLUSIONS

- Services not appearing on the Schedule of benefits.
- Procedures, which were begun by another dentist prior to a member’s eligibility to, receive benefits under this Contract.
- Prophylactic removal or impacted teeth (Asymptomatic non-pathological)

DHMO EXCLUSIONS *(continued)*

- Dental treatment for cosmetic purposes.
- Rebonding of Maryland bridge.
- Addition of a tooth or clasp to an existing partial denture. (Modification of an existing appliance)
- Procedures deemed experimental by prevailing dental standards.
- Treatment of congenital malformations, including but not limited to cleft palate, anodontia, and mandibular prognathism, and enamel hypoplasia in the absence of dental caries.
- Cases in which, in the professional judgment of the attending dentist, a satisfactory result cannot be obtained.
- Major restorative work caused by orthodontic treatment.
- The placement of bone grafts or extra- oral substances in the treatment of periodontal disorders.
- Dental implants, transplants or augmentation and any diagnostic or definitive treatment related to implants, transplants or augmentations.
- Crown lengthening procedures.
- Tissue conditioning procedures.
- Second opinions.
- Accidental injury except as provided under palliative emergency treatment.
- Periodontal maintenance procedures more than eight weeks postoperative from the surgery date other than with the general dentist provider.
- Dental services secured from any dental office other than the participating dental office selected by the subscriber, unless expressly authorized in writing by the Dental Office or as cited under "Out of Area Emergency Treatment"
- Treatment for any condition for which benefits could be recovered under any Worker's Compensation or Occupational Disease Law, even if no claim is made for such benefits.
- Diagnostic procedures for non-covered benefits.
- Splinting procedures.
- Procedures which cannot be performed by the general dentist provider due to management, medical or physical condition of the patient.
- Restorative procedures to replace and/or stabilize the loss of tooth structure from attrition.
- Treatment for any disease, condition or injuries sustained, as a result of war declared or undeclared, or if caused by atomic explosion whether or not the result of war.
- Treatment for which payment is made by any federal, state, county, municipal or other governmental agency including any foreign government.
- TMJ (Temporal Mandibular Joint) disorder or dysfunctions and related services.
- General anesthesia and IV sedation in the absence of documented medical need. "Allergy" to local anesthesia must be documented by a licensed medical allergist following testing procedures. If the patient elects general anesthesia of IV sedation in the absence of such documentation, necessitating referral to a dental office not affiliated with the Network or a dental office affiliated with the network but not responsible for providing the covered services of the Schedule of benefits, such service will not longer be covered.
- Precious and semiprecious metals.

ORTHODONTIC EXCLUSIONS

- Retreatment of prior orthodontic problem.
- Treatment of patients with severe medical disabilities which may prevent satisfactory orthodontic results.
- Replacement and/or repair of an appliance furnished to the patient which is lost or broke through no fault of the orthodontist.
- Orthognathic surgery (surgical orthodontics).
- Prophylactic removal of impacted teeth